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College of Business and Economics Department of Public  
Administration and Development Management

**An assessment on the effectiveness of one stop centers in  
supporting women and children affected by violence:  
Gandhi memorial hospital one stop center**

A Thesis submitted to College of Business and Economics,  
Addis Ababa University in the partial fulfillment of master's  
degree in Public Management and Policy

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**Advisor: Berhanu Temesgen (PhD)**

**February 2022**



**ADDIS ABABA UNIVERSITY**  
**COLLEGE OF BUSINESS AND ECONOMICS**  
**DEPARTMENT OF PUBLIC ADMINISTRATION AND DEVELOPMENT**  
**MANAGEMENT**

This is to certify that the thesis prepared by Timerawosen Tesfaye, entitled: An assessment on the effectiveness of one stop centers in supporting women and children affected by violence: Gandhi memorial hospital one stop center Addis Ababa and submitted in partial fulfillment of requirements for the degree of Master of Arts in Public Management and Policy compiles with the regulations of the university and meets the accepted standards with respect to originality and quality.

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**DECLARATION**

I the undersigned, declare that this thesis work is my original work, has not been presented for a degree in this or any other universities, and all sources of materials used for the thesis work have been fully acknowledged.

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## TABLE OF CONTENTS

CONTENTS	PAGE
Approval -----	II
Declaration -----	III
Acknowledgement -----	IV
Table of Contents -----	V-VII
Acronyms -----	VIII
Abstract -----	IX

### CHAPTER ONE

1. Introduction -----	1
1.1. Background of the Study-----	1
1.2. Statement of the Problems -----	3
1.3. Objective of the Study -----	4
1.3.1. General Objectives-----	4
1.3.2. Specific Objectives-----	4
1.4. Research Questions -----	5
1.5. Significance of the Study -----	5
1.6. Scope of the Study -----	6
1.7. Limitation of the Study-----	6
1.8. Organization of the Study -----	7

### CHAPTER TWO

2. Review of Related Literature -----	8
2.1. Conceptual definition of Effectiveness -----	8
2.2. Theoretical Review-- -----	10
2.2.1. Typologies and models of One Stop Centers, (OSCs) -----	10
2.2.2. Key Components of one Stop Centre -----	11
2.2.3. Violence against Women and Children -----	12

2.2.4. Global and Regional Estimates of Violence against Women -----	15
2.2.5. Prevalence of Violence against Women -----	15
2.2.6. Violence against Children -----	16
2.2.7. Theoretical Perspective of Violence against Women -----	17
2.3. Empirical review -----	20

### **CHAPTER THREE**

3. Methodology of the Study -----	22
3.1. Research design and Approach -----	22
3.2. Qualitative Research Approach -----	22
3.3. Population and sampling design -----	23
3.3.1. Target population of the study -----	24
3.3.2. Sample size determination -----	24
3.3.3. Sampling Techniques -----	25
3.4. Role of the Researcher-----	25
3.5. Methods Data Collection -----	26
3.5.1. Primary data -----	26
3.5.2. Secondary data -----	28
3.6. Data Analysis -----	28
3.7. Trustworthiness of the Study -----	28
3.8. Ethical consideration -----	29

### **CHAPTER FOUR**

4. Results and Discussions -----	30
4.1. Interview and FDG Participants -----	30
4.2. Revisions of Interview Protocol -----	31
4.3. Introductory Interview -----	33
4.3.1. Theme 1: “specialized training” -----	33
4.3.2. Theme 2: “essential kit/equipment” -----	33
4.3.3. Theme 3: “follow up their treatment” -----	35
4.3.4. Theme 4: “package of services and delivery model” -----	36

4.3.5. Theme 5: “safety and protection” -----	37
4.3.6. Theme 6: “police investigation and court decision” -----	38
4.3.7. Theme 7: “constraints/limitations” -----	38
4.3.8. Theme 8: “specific challenges” -----	39
4.3.9. Theme 9: “evaluate services” -----	41

## CHAPTER FIVE

5. Conclusion and Recommendation -----	42
5.1. Conclusion -----	42
5.2. Recommendations -----	43
i. For Existing One Stop Center Service -----	44
ii. For Government Authorities and Policy Makers -----	44
iii. For Survivors and their Families -----	45
iv. Further Research -----	45
References -----	47
Appendix -----	50
Annex 1: Consent form -----	50
Annex 2: Key Informant Interview Guide -----	52
Annex 3. Focus Group Discussion Guide -----	58
Annex 4. Observation Checklist Guide -----	63
Annex 5. Guiding principles when working with GBV survivors -----	64

## **Acronyms**

- VAW            Violence against Women
- VAWG        Violence against Women and Girls
- GBV            Gender Based Violence
- SGBV         Sexual and gender-based violence
- OSC            One Stop Center
- SV              Sexual Violence
- CEDAW        Convention on the Elimination of All Forms of Discrimination against  
Women
- DEVAW        Declaration on the Elimination of Violence against Women
- FDRE          Federal Democratic Republic of Ethiopia
- IRC            International Rescue Committee
- WHO            World Health Organization
- UNICEF        United Nations International Children’s Emergency Fund
- UNODC        United Nations Office on Drugs and Crime
- EDHS          Ethiopian Demographic and Health Survey
- OECD          Organization for Economic Co-operation and Development
- UDHR          Universal Declaration of Human Rights
- ICCPR         International Covenant on Civil and Political Rights
- ICESCR        International Covenant on Economic, Social and Cultural Rights
- CRC            Committee (or Convention) on the Rights of the Child

## ***Abstract***

*The purpose of this study was to assess the effectiveness of the one stop center in supporting women and children affected by violence in Mahatma Gandhi Memorial Hospital. The study deals with examining the actual experience and process of integrated service provision in the one stop center. A qualitative research method technique used and among the five approaches of qualitative research method, a phenomenological approach applied. The research explores services being rendered in the center for survivors in line with standard GBV guidelines by Inter-Agency Standing Committee (IASC) for service provision and the one stop center objective and goal. The study area is the one-stop integrated services center for violence survivors established within the hospital. Purposive sampling method is used while selecting the study area and key informant interviews, focus group discussions and observation used for data collection. The data gathered analyzed thematically. It has been found that Gandhi Memorial hospital integrated center provides medical treatment, psychosocial support, and legal assistance. The findings of the study revealed that the establishment of one stop center facilitated beneficiaries to get medical cure, psychological and legal support easily at one place. In addition to this, constraints and challenges that identified including the shortage of budget, absence of essential medical equipment's, limitation of staff development at the center, survivors preferred medical support than legal support, survivors and their families are not cooperating with legal service givers and the workload that the center was forced to serve the people who could come from all directions of Addis Ababa city.*

***Key words:*** Effectiveness, One-stop center, Violence, Survivors, Support, Women and Children

## **Chapter One: Introduction**

### **1.1 Background of the Study**

The purpose of this study is to assess the effectiveness of the one stop center in supporting women and children affected by violence in Mahatma Gandhi Memorial Hospital. The study deals with examining the actual experience and process of integrated service provision in the one stop center.

Quality, timely services to survivors of gender-based violence are lifesaving if provided as per international best practices and guidelines. Providing comprehensive integrated services to survivors of is relatively new in Ethiopia and the first ever one-stop center for GBV survivors was established in 2004 in Mahatma Gandhi Memorial Hospital.

Violence against women (VAW) is associated with harmful health consequences and is a major public health concern. VAW is also a barrier to achieving Sustainable Development Goal 5 on gender equality and women's empowerment, and Sustainable Development Goal 3 on health. The health sector is well situated to respond, as women facing violence are more likely to view health workers as trustworthy for disclosure of abuse and to use a variety of health services, including mental health, emergency department and primary care services when compared with non-abused women. A variety of one stop center (OSC) models have emerged over the years that vary in structure and services provided, resulting in discussion as to how the OSC should be defined. For the purpose of this review, the authors defined an OSC model as an interprofessional, health-system based center that provides survivor-centered health services alongside some combination of social, legal, police and/or shelter services to survivors of intimate partner violence (IPV) and/or sexual violence (Olson RMcK, et al.)

The original OSC was developed in a tertiary hospital and aimed to provide acute services to survivors of violence. Soon after OSCs were established in Malaysia in 1994, the model was replicated throughout South East Asia and Western Pacific regions. It has now been widely implemented with donor support in several African countries, and similar models are emerging in Latin America. The majority of OSCs are hospital-based, typically within tertiary care facilities, while others are stand-alone centers that provide basic health services on-site and refer for specialized and emergency services. Some OSCs are more strongly linked to the judicial system as in the case of the Thuthuzela centers in South Africa (Olson RMcK, et al).

The psychological impact of violence on women and children is changing from time to time. In order to prevent this recurrence and to respond promptly the government and non-governmental organizations are committed to preventing and responding to violence and crime in a coordinated manner. Considering and formulating the experience, a National Coordinating body of 19 institutions was convened in December 2011 by the Ministry of Justice and signed a memorandum of understanding.

One of the main objectives of the National Coordinating Body is to establish and expand an integrated justice and care center for victims of sexual violence. It includes access to prompt services, protection from harassment, encouragement of reporting, and the success of criminal investigations and trials. Accordingly, the "Integrated Women's and Children's Care and Justice Center" was opened for the first time at the Gandhi Memorial Hospital in 2004.

In addition, efforts have been made to develop and implement an executive directive for service providers participating in the center on October 23, 2004, which was slightly revised in 2011. The document's limitations are limited to federal-level integrated justice and care centers established in 2004.

## 1.2. Statement of the Problem

Violence against women and children (VAW) is a widespread and deeply entrenched problem in Ethiopia, with one of the highest rates of women and child violence in the world. According to figures from the Ethiopian Demographic and Health Survey (EDHS 2016), nearly one in four of all Ethiopian women have been the victims of physical violence, while one in 10 has been victims of rape.

Violence against women and children has a physical, psychological and social consequence that needs to be addressed in a timely manner. These include HIV and other sexually transmitted diseases, fistula, unintended pregnancy, complications of pregnancy and childbirth, maternal mortality, unsafe abortion, death, insecurity, depression, anger, anxiety, fear, self-hate, shame, self-blame, mental illness, suicidal thoughts/ attempts, blaming the survivor, social stigma, social rejection and isolation, loss of ability to function in a community.

Furthermore, the increase in the number of reported cases to the administration of criminal justice, the intensity of the attacks, and the changing nature of such attacks are of great concern. However, according to a study conducted in the past, there are gaps in the number of institutions and centers that respond to violence against women and children that needed to be further assessed focusing on service provision for violence survivors since medical and psychosocial services for survivors are lifesaving if provided in a timely Manner. (Survey, 2012 E.C) done by the one stop center.

There has been research conducted in the region in the past in Kenya and Zambia with the goal of assessing effectiveness of different one stop centers in terms of health and legal outcomes for survivors, and cost-effectiveness as well as to identify lessons learned in implementation with recommendations for both start-up and scale-up (Keesbury et al., 2012).

Looking at research conducted in Ethiopia thus far, as explored below, the researcher came to realize that there was a gap that needed to be assessed focusing on service provision for sexual violence survivors. While there are few research studies conducted on Gender based Violence and rape in Ethiopia, none of them specifically focused on the effectiveness of a one stop centers in providing integrated services for violence survivors. Research in the past conducted included, gender-based violence and its relation to HIV infection (Gulelat, 2005), assessment of post rape care services in Gandhi Memorial Hospital Addis Ababa (Kidist, 2019).

While there are few research studies conducted on Gender based violence and rape in Ethiopia, none of them specifically focused on the effectiveness of a one stop centers in providing integrated services for violence survivors. This research is different from the above as focuses on the effectiveness of the one stop center integrated service for survivors by exploring and assessing the one stop center day to day services.

### **1.3. Objectives of the study**

#### **1.3.1. General objective**

The general objective of the study is to examine the effectiveness of one stop center in providing integrated care and justice system.

#### **1.3.2. Specific objectives of the study**

- To examine the effectiveness of the one stop center in providing integrated care.
- To explore gaps and limitations in service delivery as per their standard operation procedure (SOP).
- To assess and evaluate the service center capacity and number of victims that seek psychosocial help and proper medical attention are balanced.

- To assess the level of openness and supportiveness of victims during receiving service and ongoing medical and legal process.

#### **1.4. Research Questions**

Four primary research questions guided this study:

1. What are the one stop integrated care center constraints/limitations for providing an effective service?
2. Do victims/survivors get the proper attention, care and benefit at the one-stop center?
3. Is the center sustainable in terms of finance and professional personnel to provide consistent service to survivors?
4. What are the current challenges and possible way forward solutions?

#### **1.5. Significance of the study**

The study intended to assist in revealing the factors that ensure the effective operation of the centers. It will help the center to narrow gaps in service provision and improve service quality. The study will also be able to come up implementable solution for the problems identified; thus, it can be used as a guide to tackle the problems faced by the center and improve service provision for violence survivors. It also can be used as a reference for the newly establishing similar one stop centers in other hospitals. In addition, it can be used as a reference for further measures if they are to be taken by other centers to address similar or related problems. This study also will offer a systematic evidence on the effectiveness of OSCs in the Ethiopian context which can guide national-level policymakers and program managers in introducing or adapting the OSC model in large scope. The study is also important to the researcher as it add theoretical and practical knowledge on the area. The study will also be significant to scholars and researchers in other higher learning institutions who require basis for further research in this area.

## **1.6. Scope of the study**

### **2. Methodological scope**

The study highly concentrates on assessing the effectiveness of one stop center located at Gandhi Memorial hospital in supporting women and children affected by violence. The center provides integrated services under one roof (medical, psychosocial, and legal). The assessment will be conducted based on their designed log frame which sees output, activity, impact and outcome by certain evaluation criteria and specific indicators. There are four one stop centers in Addis Ababa including in Gandhi memorial hospital.

Also, concentrates to assessing the sustainability of the program through its various dimensions (financial, economic, social, and environmental).

### **3. Geographic scope**

The study site is at Gandhi Memorial hospital. Other one stop centers will not be considered. The other three located in Paulos, Menelik and Tirunesh Dibaba hospital one stop centers are newly established and not organized as equal to Gandhi memorial hospital. Mainly due to this reason, time, and budget constraints the researcher only focuses only Gandhi memorial hospital one stop center. However, the one stop center at Gandhi will be a good representative of the one stop services as various cases and informants (women and child) are being entertained and examined at the center. Therefore, the health facility-based, hospital-owned one-stop center model facility will be explored in this study.

## **1.7. Limitations of the study**

The study lacks access to various research literatures specifically done on effectiveness of services on supporting women and children affected by violence in Ethiopia. Some research literatures found only focuses on the overall issue of violence against women and children.

In some cases, effectiveness concept is being used to reflect overall performance of an organization, since it is a broader concept it gets challenging to explore the efficiency factor if it is included under effectiveness assessment. The study also lacks access to survivors for interview or questioner who directly recipient of the one-stop center services due to victim's privacy and the center rule.

### **1.8. Organization of the Study**

The rest of the research will be organized as follows. Section two reviews the theoretical and empirical literatures on violence against women and children. Section three gives details of the method of research used in this study. Section four presents the data analysis and discuss on the findings. Finally, the conclusions and recommendations of the study will be presented in the fifth section. A "Bibliography" of related literature refereed to while writing the paper and annexes will be included after section five.

## Chapter Two: Review of Related Literature

### 2.3. Conceptual definition of Effectiveness

Effectiveness statements are typically not descriptive; they are evaluative and often normative. That is, they are generally not attempts to answer the question "How is entity X performing?" Instead, they usually attempt to answer, "How well is entity X performing?" and often "How much better should entity X perform?" The central differentiation among current effectiveness statements is in how they specify the evaluative criteria used to define "how well" the entity is performing or could perform (Terry, Edward J and Stuart Jay, 1980).

“Effectiveness is the extent to which the development intervention’s objectives were achieved, or are expected to be achieved, considering their relative importance. Also used as an aggregate measure of (or judgment about) the merit or worth of an activity, i.e., the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with positive institutional development impact.” Analysis of effectiveness involves taking account of the relative importance of the objectives or results.

It clarifies that effectiveness should analyze progress towards objectives along the results chain / causal pathway. In contrast to impact, which looks at higher-order effects and broader changes to which an intervention may be contributing, effectiveness is concerned with more closely attributable results as OECD/DAC Revised Evaluation Criteria Definitions and Principles for Use (November 2018).

Theorists loosely grouped under the "systems" approach to organizational effectiveness offer a variety of ways to solve the criterion problem. At the most global level, functional analysis (Parsons, 1960; Lyden, 1975) argues that organizations may be evaluated by how well they solve the four essential problems: **goal attainment, adaptation, integration, and pattern**

**maintenance.** More operationally (Evan, 1976) draws on systems theory to suggest categories of measurable variables that might be related to effectiveness. An ingenious middle ground is proposed by Yuchtman and Sea- shore in what they call the “systems resource approach”. They argue that the three basic processes in an open-systems view of organizations - resource acquisition, transformation, and disposal - are tightly interconnected, so that overall effectiveness may be assessed at any point in the loop. They choose the input-acquisition process and define effectiveness as "the ability of the organization ... to exploit its environment in the acquisition of scarce and valued resources" (1967, p. 898).

Several models or definitions of effectiveness have emerged in the literature, including the ideal type or bureaucratic model (effectiveness as matching the ideal characteristics of a bureaucratic organization), the goal model (effectiveness as accomplishing goals), the natural systems model (effectiveness as obtaining needed resources), the strategic constituencies model (effectiveness as satisfying important stakeholders), the internal processes model (effectiveness as high quality internal processes), the paradox model (effectiveness as the presence of simultaneous opposites), and the abundance model (effectiveness as producing flourishing and virtuousness). The criteria for evaluating effectiveness in each of these models differ, but each has a legitimate claim to be a useful approach to assessing and producing valuable outcomes.

Effectiveness is the power to produce the desired result and the capacity or potential for achieving results. Organizational effectiveness is discussed by Zheng et al (2010) in combination with strategy and knowledge management, where they use the definition as “*the degree to which an organization/institution realizes its goals*” (p.18). “*Effectiveness is often measured as the quality of the desired result and achieving results*”.

Meyer and Herscovitch (2001) analyzed organizational effectiveness through organizational commitment. Commitment in the workplace may take various forms, such as relationship between leader and staff, employee's identification with the organization, involvement in the decision-making process, psychological attachment felt by an individual.

Organizational effectiveness helps to assess the progress towards mission fulfillment and goal achievement. To improve organizational effectiveness management should strive for better communication, interaction, leadership, direction, adaptability and positive environment (Heilman and Kennedy – Philips, 2011)

## **2.4. Theoretical Literature**

### **2.4.1. Typologies and models of One Stop Centers, (OSCs)**

According to a review and evaluation of multi sectorial responses services (one stop center) for gender-based violence study made in Kenya there are three types of OSC models are found in Kenya and Zambia. “The assessment found that three OSC models have been implemented in the two countries. The first type is the health facility-based OSC, —owned by a hospital, implemented by the health facility itself, and working directly with donors to establish and manage OSC functions that are integrated into the health facility ‘s routine activities. The second type is the health facility-based OSC, —owned, by a non-governmental organization (NGO), in which NGOs establish separate centres within existing health facilities to provide —wrap-around services that strengthen and expand existing clinical services provided by the health facility. This is a common model across African countries. The third type is the stand-alone, NGO—owned OSC which provides primarily legal and psychosocial support onsite, while survivors are referred elsewhere for health services.” (Jill Keesbury, W. Onyango-Ouma- page 7).

### 2.4.2. Key Components of One Stop Centre

Although differs from place to place, the key components of one stop centers include the following major services.

- 1- Clinical services which include comprehensive medical examination and treatment, laboratory tests, emergency contraception, etc.
- 2- Police/Justice: services such as legal counsel, statement taking and documentation, collection of forensic evidence, ensuring safety of the survivor.
- 3- Psychosocial support: includes services such as provision of mental and psychosocial support, provision of safe houses, awareness raising, stigma reduction, referral of services

Although there are several indicators of success for measuring the effectiveness of the one stop center, the following will be the key areas:

- The availability of services
- Adequate number of staff, staff readiness and trainings
- Infrastructure
- Availability of essential equipment and supplies
- Existence of referral system and guidelines and follow-up care
- Survivors' perceptions of the medical care they received, and the actual services received
- Provider and client relationship
- Duration of services
- Accessibility
- Are services as acceptable and address their medical needs?
- Are the services considered to provide survivors the much-needed privacy and confidentiality while seeking care?

- Is there empathy showed by the service providers?
- Do survivors spend an appropriate amount of time?
- Is there cost or free all the services?
- Existence of psycho-social support with the framework of support groups for SGBV survivors
- Provision of legal services, including legal advice and court preparation, enhances legal outcomes.

Overall, the effectiveness will be evaluated from the:

- 2) Infrastructure point of view
- 3) Service provision point of view
- 4) Integration of services point of view
- 5) Personnel point of view (Adequacy of staff, the various functions of staff, case administrator, case worker, police facilitation officer, personal/legal officers' counselor, IT, multipurpose help center)
- 6) Case referral and capacity to follow up
- 7) Case Management (Population Council, 2012)

### **2.4.3. Violence against Women and Children**

Violence against women and children includes acts of physical, psychological, economic and sexual abuse. Declaration of Violence Against Women and Children for the first time, widely recognized as a violation of human rights for the first time. According to the Elimination of all Forms of Violence Against Women (DEVAW), violence against women includes any act of coercion, physical or sexual or psychological abuse, coercion or improper deprivation of liberty. It states that life and social life are at stick.

Although violence is against anyone, women and children are vulnerable to harmful cultural, social, economic, and political influences.

In accordance with international law (UDHR), ICCPR, ICESCR, CRC, the protection of women's and children's rights without discrimination based on their gender and age, the protection and protection of all rights, and the economic and political rights of countries where women and children are equal. They are responsible for doing so.

In addition to the international laws adopted by Ethiopia, the policies it has enacted include the FDRE Constitution (Articles 13-44), Family Law, Criminal Law (620-645), Trafficking in Persons Proclamation 1178/2020, Computer Crime Proclamation No. 958/2016 (Article 12). In addition to recognizing their rights, they will work to establish a justice system and other means of responding to violations in order to ensure that their rights are respected.

Overall, one in three women worldwide, including Ethiopia, accounted for 35 percent of all physical or sexual assaults at some point in their lives as per WHO's report on violence on women (WHO, 29 November 2017)

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (WHO, 9 March 2021)

## **Types of violence**

### **1. Intimate partner violence**

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner —a husband, boyfriend or lover, either current or past. Women may suffer several types of violence

by a male partner: physical violence, emotional/psychological abuse, controlling behaviors, and sexual violence.

## **2. Physical violence**

This includes causing injury or harm to the body by, for example, hitting, kicking or beating, pushing, hurting with a weapon.

## **3. Emotional/psychological abuse**

This can include many types of behaviors such as criticizing her repeatedly, calling her names or telling her she is ugly or stupid, threatening to hurt her or her children, threatening to destroy things she cares about and belittling or humiliating her in public.

## **4. Controlling behaviors**

This includes, for example: not allowing a woman to go out of the home or to see family or friends, insisting on knowing where she is always, often being suspicious that she is unfaithful, not allowing her to seek health care without permission and leaving her without money to run the home.

## **5. Sexual violence**

Sexual violence is "any sexual act, attempt to obtain a sexual act or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced, attempted rape, unwanted sexual touching and other non-contact forms such as:

- Forcing her to have sex or perform sexual acts when she doesn't want to
- Harming her during sex
- Forcing her to have sex without protection from pregnancy or infection (World Health Organization 2013).

#### **2.4.4. Global and regional estimates of violence against women**

As per WHO's factsheet on March 9, 2021, over a quarter of women aged 15-49 years who have been in a relationship have been subjected to physical and/or sexual violence by their intimate partner at least once in their lifetime (since age 15). The prevalence estimates of lifetime intimate partner violence range from 20% in the Western Pacific, 22% in high-income countries and Europe and 25% in the WHO regions of the Americas to 33% in the WHO African region, 31% in the WHO Eastern Mediterranean region, and 33% in the WHO South-East Asia region.

#### **2.2.5. Prevalence of Violence against Women**

Some studies undertaken at the national level, indicate that violence against women in Ethiopia is still pervasive and that there is a need for due attention from a range of stakeholders, including legislative and judiciary organs as well as government and CSOs. Women in different parts of Ethiopia experience violence in various forms. For example, a large proportion, 25 percent of Ethiopian women experienced their first sexual experiences under coercion as indicated in a study conducted in 2010 in seven regions of Ethiopia. The study further indicated that 92 percent of the perpetrators in these cases were spouses, while 6 percent were boyfriends or fiancés, and 2 percent were acquaintances or classmates. The study also showed a high level of acceptance of violence against women, where 35 percent of the women said that domestic violence was justified if the woman argues with her husband; 32 percent said it was acceptable if the woman refused to have sex; and 31 percent said it was justified if the woman neglected a child. Overall, 69 percent of the respondents in this national survey agreed that any one of these reasons could be enough to justify beating a woman. Similarly, men have a high acceptance for wife beating with highest acceptance rates among men in Somali (58 percent) and SNNP (56 percent) In a study undertaken in 2010 on young adults aged 15 to 24 years, it was found that physical domestic violence was

experienced by 10 percent of married women in the study group. In 2010, a national Gender Survey also showed that 7 percent of ever-married women had experienced psychological abuse and insults. Though there is some statistics on early marriage, FGM and to some extent on reported cases of civil and crime cases, it is also worth noting that other forms of violence such as economic and psychological violence may be underreported or even not recognized (UN Women, 2016).

### **2.2.6. Violence against Children**

Violence against children includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers.

Globally, it is estimated that up to 1 billion children aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect in the past year (1). Experiencing violence in childhood impacts lifelong health and well-being.

The World Health Organization defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (WHO, 1999).

#### **Types of violence against children**

Most violence against children involves at least one of five main types of interpersonal violence that tend to occur at different stages in a child's development.

- Maltreatment (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by

parents, caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages.

- Bullying (including cyber-bullying) is unwanted aggressive behavior by another child or group of children who are neither siblings nor in a romantic relationship with the victim. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.
- Youth violence is concentrated among children and young adults aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes bullying and physical assault with or without weapons (such as guns and knives), and may involve gang violence.
- Sexual violence includes non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact (such as voyeurism or sexual harassment); acts of sexual trafficking committed against someone who is unable to consent or refuse; and online exploitation.
- Emotional or psychological violence includes restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment (WHO, 8 June 2020)

### **2.2.7. Theoretical Perspective of Violence against Women**

This study uses the feminist theoretical lens. The feminist movement in the early second half of the past century stood out because it denounced cases of violence against women, casting light on a reality that, until then, had only been mentioned in the private sphere. Violence in the home context continued without anybody doing or saying anything. Until that time, it had not been openly manifested and was supported by contemporary social conditions.

The summary of different international conferences held in the 20<sup>th</sup> century contains the propositions and definitions of minimal human rights for all people on the planet, which undoubtedly affected the detection and investigation of gender violence against women. These conventions were: Charter of the United Nations (1945); Convention on genocide (1948); International covenant on civil and political rights (1966); International covenant on economic, social and cultural rights (1966); International convention on the elimination of all forms of racial discrimination (1965); Convention on the elimination of all forms of discrimination against women (1979); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984); Convention on the rights of the child (1989); and the Inter-American Convention on the prevention, punishment and eradication of violence against women - Convention of Belém do Pará (1994).

These conventions established legal frameworks to protect human rights, with positive repercussions for the advanced understanding and eradication of violence against women.

Gender violence was influenced by feminist groups from Western countries, which denounced people who degrade women's dignity through violence. As a result of the identification of violence against women, feminist groups have been joined by other actors, such as human rights defense associations and international organizations, who analyze and attempt to help decreasing the problem.

In order to understand the gender violence designation, we need to consider the social character of traits attributed to men and women. Most female and male traits are cultural constructions. They are products of society and do not necessarily derive from nature.

Gender violence is exercised by men against women, in which the aggressor's and the victim's gender are closely connected with the explanation of this violence. Thus, it affects women due to

the simple fact of being women, that is, it is violence perpetrated by men to maintain control and dominion over women.

Men's roles and behaviors are considered socially more valuable. For example, crying is disdained, violent responses are looked upon positively, and housework (although fundamental) remains almost unnoticed to men, although justifying that it is carried out by women.

The gender category presupposes the understanding of relations established between the sexes in society, differentiating between biological and social sex. While biological sex refers to anatomic-physiological differences between men and women, social sex is related to how these differences behave in different societies throughout history.

In all cultures across the world, women live in socially unequal conditions towards men. These inequalities acquire different manifestations and magnitudes.

The definition of gender implies two levels, that is, gender as a constitutive element of social relations, based on perceptible differences between the two sexes; and gender as a basic form of representing power relations, in which dominant actions are presented as natural and unquestionable.

International concerns about the phenomenon of violence against women demand analyses and studies about the issue, as this violence deteriorates women's individual and family health. Women who resist against an abusive relation indefinitely end up losing their individual (physical and mental) health, which consequently affects the family's health.

The United Nations convention on the eradication of violence against women, which the UN General Assembly adopted in 1993, defined violence as any act of gender-based violence that produces or can produce physical, sexual or mental harm or suffering in women, including threats, coercion or arbitrary privation of freedom in public as well as in private life (L Casique, 2006).

### 2.3. Empirical review

Previous researchers have made studies related to violence against women. One such research is done by Kidist Mekonnen (2019) as part of partial fulfillment of the requirement for the Degree of master's in social work entitled '*Assessment of Post Rape Care Services in Gandhi Memorial Hospital Addis Ababa*' the paper focused on to assess the availability and accessibility of services for survivors of rape in Mahatma Gandhi Memorial Hospital. The study aimed exploring services being rendered in the center for survivors in line with standard GBV guidelines for service provision. The study used qualitative research method, an instrumental case study. in which the investigator explores a bounded system (a case) or multiple bounded systems. In this study the researcher didn't mention about effectiveness of the integrated service at the one-stop-center. The study findings laid on that "Not all service providers working in the center are trained on specialized GBV trainings for working with survivors, including child survivors. Furthermore, linking survivors with the option of rehabilitation and group support programs is found as a gap".

Another notable research is a thesis submitted for the degree of master's in human rights by Kebkab Sergiw (2011) with a title '*Marital Rape as a Human Rights Violation of Women*' This research has the general objective of showing the gaps in the legal frameworks of international and national laws on marital rape and exemplifies problems that impede legal institutions from preventing and dealing with marital rape. The research focused on one of the types of violence against women; marital rape that is committed on wives in relation with legal, cultural as well as institutional barriers by assessing and exploring the gaps in the legal frameworks. This study used a qualitative method of study, which a case study by way of interviewing victim individuals was conducted and questionnaires that were open ended were distributed to respondents to get detailed answers to the problems. The findings of the study on marital rape estimates shows that 60% of

respondents had unwanted sexual intercourse. However, 57.15 % of victim respondents stated that they have not reported the incident of marital rape. The unwanted sexual aggression had psychological and physical consequences on the victim. Moreover, the commission of the act resulted in violation of series of fundamental rights of women. The study lacks clear explanation of methods of the research.

In a similar manner, Gulelat Amdie (2005) conducted a research in fulfillment of the requirements for the Degree Master of Public Health in entitled '*Gender Based Violence and Risk of HIV Infection Among Women Attending VCT Services in Addis Ababa City*' This study was conducted to measure the prevalence of various forms of gender-based violence, intimate partner physical and sexual violence and focused to assess associations between gender-based violence, HIV risk behaviors and HIV infection among women attending voluntary counseling and testing service in Addis Ababa City. The finding of this study emphasized on that women partnered with violent men are at increased risk of HIV infection. Intimate partner violence was associated with HIV seropositivity that abusive partners are more likely to have HIV and place their female partners at high risk of HIV. Methods of study not sufficiently and clearly explained in the study.

While there are few research studies conducted on Gender based violence and rape in Ethiopia, none of them specifically focused on the effectiveness of a one stop centers in providing integrated services for violence survivors. This research is different from the above as focuses on the effectiveness of the one stop center integrated service for survivors by exploring and assessing based on its log framework and indicators.

## **Chapter Three: Methodology**

This chapter gives details of the method of research used in this study, which was based in the constructivist paradigm, used a phenomenological strategy to explain the effectiveness of one stop centers in supporting women and children affected by violence: in the case of Gandhi Memorial Hospital one stop center. The chapter describes the research paradigm, approach, design, data collection tools and procedures, method of analysis and ethical consideration that were used to achieve the purposes of the study.

### **3.1. Research Design and Approach**

In this research work, detailed information was collected for the purpose of exploring the effectiveness of the integrated service for women and children affected by violence in Gandhi Memorial Hospital one-stop-center. A qualitative research method has been used. A qualitative research method is found to be more suitable by the researcher to purposefully select participants and documents in order to better understand the problem and the research questions as well as to assess the effectiveness of the services. This research method also offers a unique opportunity to gain in-depth insight from service providers. Qualitative research has been conducted because a problem or issue needs to be explored and when a complex, detailed understanding of an issue is needed (Creswell, 2007). The qualitative research methods used for this study are described further below and included purposive sampling, open-ended interviewing, and systematic data analysis procedures.

### **3.2. Qualitative Research Approach**

A qualitative research approach for this study was chosen because qualitative methods are especially useful in discovering the meaning that people give to events that they experience

(Merriam, 1998). Specifically, the phenomenological method was used to understand how participants make meaning of the phenomenon being studied, i.e., the effectiveness of one stop integrated service to support survivors. Phenomenology is effective in studying a small number of subjects in this case, 13 participants to identify the core of their experiences with the phenomenon (Creswell, 2003).

This study employed a constructivist paradigm to assess the effectiveness of one stop centers in supporting women and children affected by violence. Constructivists focus on understanding and reconstructing the meanings that people (including the researcher) hold about the phenomenon being studied (Guba & Lincoln, 1994). Constructivists create knowledge through interaction between the researcher and participants (Guba & Lincoln, 1994), using dialogue and reasoning as the primary methods of investigation. Finally, constructivist researchers return frequently to the sources of data, asking what they meant to the participant and trying to integrate those with their meaning to the researcher (Rudestam & Newton, 1992). Thus, for this study, in-depth interviews were conducted with six staff members of the center. Data were continually scrutinized to understand the participants' perceptions of their one stop center experience.

### **3.3. Population and sampling design**

The Gandhi Memorial Hospital one stop center staff members who had a minimum of three years' experience were selected for participants in this study since they would be "knowledgeable informants" Because the goal of the study was to assess the effectiveness of the one stop center service. These staff members were contacted directly by the researcher. Participants who were willing to help were given details about the purpose of the study and the needs of the researcher. Ghandi Memorial Hospital one stop center coordinator routinely relied on staff to help identify the informants who met the researcher's selection criteria of the study. Once

potential participants had been identified, an e-mail was sent to them with the Informed Consent Form (ICF) that included a description of the research study, research procedures, risks and benefits of participation in the study, participant rights, and protection of confidentiality. Staff members who agreed on the consent form became participants in the study. Recruitment and the Gandhi Memorial Hospital one stop center staff members who had a minimum of three years' experience were selected for participants in this study since they would be "knowledgeable informants" Because the goal of the study was to assess the effectiveness of the one stop center service. to be redundant (Merriam, 1998). At this point a total of 13 participants had been interviewed and took the discussion on focus group discussion session.

### **3.3.1. Target population of the study**

Target populations of this study are service providers in the one-stop integrated services center in Mahatma Gandhi Memorial hospital. To select the participants of the study, purposive sampling method was applied.

### **3.3.2. Sample size determination**

As sampling in qualitative study tends to be with small number of people nested in their context in order to explore in-depth, 6 key informant interviews were conducted with the medical, psychosocial, legal and protection division representatives of the center, 1 focus group discussion were conducted with groups consisting of seven participants of medical, psychosocial, legal and protection professionals, introductory interview were conducted with the Medical Director of Gandhi Memorial Hospital. Additionally, a thorough observation service mapping was conducted in the center by the researcher to further triangulate data gathered through focus group discussions and key informant interviews.

### **3.3.3. Sampling Techniques**

The best and ethical way to collect information on sexual violence is through specialized service providers (IRC, 2014). The factors taken into consideration to select the samples were the roles and responsibilities of the service providers, consent to take part in the assessment and experience rendering services to survivors of gender-based violence in the hospital.

### **3.4. Role of the Researcher**

In qualitative research, the researcher is the primary research instrument. What the researcher brings to the investigation from his/her own background and identity should be treated as his or her bias (Maxwell, 2005). Since qualitative research is interpretative research, researcher biases, beliefs, and assumptions can intrude into the analysis of data (Strauss & Corbin, 1998). Social researchers should attempt to neutralize or bracket their biases through full disclosure (Altheide & Johnson, 1994). The researcher of this study acknowledged that her personal and work background could influence her interpretation of data.

To minimize any personal bias on the results of this study, member checks were utilized during and after interviews to increase the credibility, validity, and transferability of the study results (Lincoln & Guba, 1985). During each interview, the researcher also restated and summarized information, questioning participants on the accuracy of the information. After the interviews had been transcribed, the researcher asked each participant to review the content of his or her transcript for accuracy. In addition, the researcher consulted her advisor throughout the evolution of this study. Direction from the faculty advisor helped the researcher to focus on relevant details that participants offered, which led the researcher to develop themes from the data. Lastly, the researcher included ample and relevant quotes from participants to substantiate the findings of the study.

### **3.5. Methods of Data Collection**

While data collection and data analysis activities were intricately woven together throughout this phase of the study, for the sake of clarity they will be described separately. The study was attempted to gather data from both primary and secondary data collection sources.

#### **3.5.1. Primary data**

Collected through key-informants' open-ended interview to understand service provision, infrastructure of the one stop center, as well as their acceptability, cost and effect on health outcomes. Also, a focus group discussion and observation guide used to collect primary sources of data.

##### **A. Key informant Interviews**

For this study, qualitative interviews were the primary method of data collection for three reasons. Qualitative interviewing is appropriately used when “studying people’s understanding of the meaning in their lived world” (Kvale, 1996). In fact, interviewing is the best technique to use “to find out those things we cannot directly observe...feelings, thoughts, and intentions” (Merriam, 1998). Qualitative interviews result in *thick descriptions* of the subject being studied (Rubin & Rubin, 1995). Interviews also allow for *triangulation* of information obtained from other sources (Lincoln & Guba, 1985). For this study, all interviews were conducted face to face for convenience of the participant. The face to face served as efficient ways to conduct the interviews, making it possible for schedules to participate in the study. As a first step in the interview process, participants were reminded of the purpose of the study, research procedures, expected benefits, their right to withdraw from the study at any time, and protection of confidentiality. The researcher identified herself as a second-degree student at Addis Ababa University.

Notes were taken during all interviews, enabling the researcher to track key points to return to later in the interview and for use during data analysis. A semi-structured interview approach was used to carry on conversations that would elicit rich data that could be used in qualitative analysis (Lofland, 1971). Semi structured interviews give participants more room to answer in terms of what is important to them (Miles & Huberman, 1994; Strauss & Corbin, 1998) and to control the introduction and flow of topics (Mishler, 1986).

Although the interviews were semi-structured in the early stages, they became more structured in the later stages of triangulation and member checking (Lincoln & Guba, 1985). Participants were given the interview protocol approximately a week before their scheduled interview so that they would have time to think about and prepare their responses to the initial questions. Mostly open-ended questions were used throughout the remainder of the interview to encourage participants to talk freely and respond openly to queries. Probing questions were used, when necessary, to encourage participants to elaborate on or clarify a response (Rubin & Rubin, 1995) or explore root experiences (Seidman, 1991). Furthermore, participants were frequently asked “why” after responding to interview questions. Asking participants “why” the researcher’s attempt was to provide ample think time so that the participant could fully think about and elaborate on their experiences.

### **B. Focus group discussions**

Field notes served as a supporting data source for this study. Field notes were taken during each interview and later analyzed and compared to the interview transcriptions (Maxwell, 2005). seven out of thirteen participants took a part in focus group discussion. On the first page of each set of notes, the researcher recorded the date and time and a working title that indicated the content of the notes. Topics addressed in the group discussion included events that participants recalled,

the researcher's speculations about emerging themes, points of clarification, and any connections that the researcher detected between or among participants' perceptions (Bogdan & Biklin, 1982). In the group discussion included observations about the participant's attitude and direct quotes that caught the attention of the researcher. The researcher immediately highlighted quotes from participants that caught her attention so that they could be easily found during data analysis.

### **3.5.2. Secondary data**

Secondary sources of data are gathered from different published articles, reports, unpublished resources, previously conducted related studies, other relevant internet sources and through review of the one stop center records/documents.

### **3.6. Data Analysis**

Analysis occurred in three phases. First, interview transcripts were reviewed several times, searching for "recurring regularities" (Merriam, 1998). The researcher highlighted quotes and phrases from the interviews that were significant to the study. Using the constant comparative method (Glaser & Strauss, 1967), the researcher went back and forth among transcripts until categories emerged that were consistent, yet distinct (Marshall & Rossman, 1989). The researcher named and coded the transcripts. Second, the researcher brought together the coded interviews and field notes and looked for relationships within and across the data sources. Finally, the researcher integrated and refined the categories until themes solidified (Strauss & Corbin, 1998).

### **3.7. Trustworthiness of the Study**

Reliability is an area for which qualitative research is sometimes criticized. In general terms, *reliability* refers to the extent in which research findings can be replicated. Denscombe (2002) emphasized that in social research two main questions need to be addressed when determining reliability: (a) Are the data valid? and (b) Are the methods reliable? To increase the trustworthiness of the study's findings, the researcher employed strategies suggested by Lincoln

and Guba (1985). The researcher decreased threats to *credibility* by triangulating data. The researcher provided an audit trail by describing in detail how data was collected, how categories were derived, and how decisions were made throughout the inquiry (Merriam, 1998). To increase *conformability*, the researcher attempted to control for bias by constantly comparing data, searching the literature, obtaining multiple viewpoints (Strauss & Corbin, 1998), searching for negative instances of the phenomenon, and checking and rechecking data (Marshall & Rossman, 1989). Triangulation of data is of critical importance to the trustworthiness of qualitative studies. In this study, interviews and field notes were compared to ensure trustworthiness.

### **3.8. Ethical Consideration**

The ethical clearance obtained from Addis Ababa Public Health Research and Emergency Management Directorate and formal communication was made with Federal Democratic Republic of Ethiopia Ministry of Justice (as it is the ministry the integrated services center directly reports to), Addis Ababa Police Commission and Gandhi Memorial Hospital to get consent and support with a formal support letter from Addis Ababa University department of Public Administration and Development Management. Efforts been made to make the research process professional and ethical. To this end, the researcher clearly informed the organization who has provided the required data for the purpose of the study i.e., purely for academic. In addition, the study was based on their consents which was presented as a written and signed form prior to any data collection process. The researcher also not personalize any of the findings during data presentations, analysis and interpretation. Also, additional safeguards were taken to make sure all those participating in the interview and discussion were above 18 years of age. Furthermore, all the materials that have been used for this research would be duly acknowledged.

## **Chapter Four: Results and Discussions**

The primary purpose of this study was to examine the effectiveness of the one stop center in providing integrated care and explore gaps and limitations in service delivery as per their standard operation procedure (SOP). The other purpose of the study was to assess and evaluate the service center capacity and number of victims that seek psychosocial help and proper medical attention are balanced. Participants' experiences and feedback added insight to the research questions posed in this study. By closely looking at the overall operations, limitation and strength of the center, to provide relevant recommendations for the health professionals, law makers and the community they go back. In this chapter, research questions are addressed with supporting evidence and feedback from the participants.

### **4.1. Interview and FDG Participants**

The results of this qualitative study are based on interviews and focus group discussion of thirteen participants from Gandhi Memorial Hospital's One Stop center. All informants are females but one, and voluntarily participated in the study. The staff members of the center were initially solicited through telephone conversation. Those informants then contacted some of their bosses, who then subsequently agreed to be part of the study. Six out of thirteen participants had been interviewed and the rest seven participants took a part in focus group discussion.

The thirteen participants in this study were enrolled in different postsecondary institutions and universities. Each participant experienced in the center for three or more years. Of the thirteen total participants, two experienced for all four years in Gandhi Memorial Hospital's one stop center, the rest of them had three years of experience in the same center. The participants were the staff members who came from different government offices including Ghandi Hospital.

The participants were assigned by their respective government offices. These offices are Ministry of Justice, Addis Ababa Police Commission and Gandhi Hospital. Three interviewees attended medical college and received Doctor of Medicine degrees, while three interviewees enrolled in nursing school and awarded degrees. Two interviewees have got LLB degrees from different universities and three participants were sociology graduates. Two participants graduated from Police Training Institute.

Each participant was interviewed in person. Face to face interview is an effective and necessary way to communicate with participants. Recording and transcription of interviews was done by researcher who conducted this study. Interviews were transcribed within a couple of days of occurrence. Interview times varied and were scheduled at times conducive for both participants and the researcher. The researcher also took field notes during each interview. All interviews were conducted during the months of July and August 2021.

#### **4.2. Revisions of Interview Protocol**

The initial interview protocol had a lengthy introduction about the purpose of the study, who would have access to the participant's responses, the participant's risks and rights, and when the interview data would be discarded. The intent was that the researcher would read each participant the introduction verbatim as part of the interview. The researcher orally improvised this introduction many times when talking with participants in order to get the initial interview protocol started in a timely and comfortable manner. All thirteen participants received the initial interview protocol ahead of time, so the researcher felt comfortable hitting the major points outlined in the introduction and asking each participant, "Do you have any questions before we begin?"

Most interview questions were asked exactly as they were written. However, the researcher often followed up the semi-structured questions with open-ended questions such as, “Why?” and “Can you tell me more?” This was the researcher’s way to get at deeper meaning and richer understanding of the participant’s experiences.

Based on the guidance of the primary research questions of the study; nine distinct themes emerged from the research data. The major themes identified from the results of this study included:

1. One stop center staff member attended any *specialized training* on clinical care and social work?
2. What are the *essential kit/equipment’s* available in the center?
3. Survivors who were under medical care and counseling *follow up their treatment* appropriately.
4. What *package of services and delivery model* do victims get under psychological support?
5. What are the specific services under *safety and protection* provide?
6. How long a *police investigation* takes to present a case to a court and a *court decision* to finalize a case?
7. The main *constraints/limitations* for providing expected treatment to survivors.
8. What are the *specific challenges* to provide services in one stop center?
9. How often *evaluate services* in rendering survivors in a center.

Themes 1 to 9 answered the above mentioned four research questions. Each theme is discussed in detail below.

### 4.3. Introductory Interview

Introductory interview was conducted with the medical director of Gandhi Memorial Hospital, and he has been serving in director office, responded as follows:

The researcher started her interview to begin with a question: “How integrated care services provide to survivors?” The director reported that “In our one stop center integrated services are provided for seven days and 24 hours. The services are classified into three cases which are identified as Medical, Psychological and Legal services. And then legal service has two components, known as police investigation team and Attorney service team.” added. The following two questions were also followed, “How the survivors get services in the center?” and “How information goes to the societies in order to get awareness about the service of the center?”. The director said that “Information disseminates through different platforms, like meetings, posters, fliers and brushers. And sometimes use medias when unique cases happen in relation to sexual violence, for example, an information falsely broadcasted that *‘one hundred one children were sexually violated by their fathers.’* This was not happened, but medias had approached us in order to search the truth. On the other hand, we may get media outlet on some occasions, like March 8, Women’s day and White Raven day.”

#### 1.1.1. Theme 1: “specialized training”

Seven out of the thirteen participants took specialized trainings. Four participants who assigned from hospital, attained on clinical care and the other three participants who came from other sectors, received social work training.

Participant 2 who was 28 years old, MD degree graduate, and having three years’ experience noted that, “when I was assigned to this center, I took on job training in the earliest time of my service. The training was given by senior specialist doctors who have specialized in

*uterine and fetal*. Such trainings are funded by Ministries of Justice, and women and children affairs. However, I didn't take any social work training yet." Participant 3 who aged 29, medical doctor and offering her service in the center since 1918, reported that, "I received training three times on clinical care for survivors and onetime participated in one workshop on legal service which was organized by Ministry of Attorney. But I didn't get any opportunity to have knowledge about social work".

Participant 4, thirty-five years old, graduated in nursing, having four years' experience in the center, said that "since I have long time in this center, I have got frequent trainings in relation to my career, such as clinical care, legal and psychological trainings and workshops. These workshops and trainings were organized by governmental offices collaborating with non-governmental organizations. Truly speaking, I significantly benefited from all trainings".

Participant 5, aged 30years, first degree graduate in sociology with three years' experience in the center said that "I am an employee of Gandhi Hospital and assigned in this center since 1917. For the last couple of years now, I took a part only two times in workshop and training on social work. One time attended in seminar which was conducted for legal service aspects". Participant 6, forty-two years old, law graduate, having four years' experience in the center reported that "since I was assigned for this center, I haven't been invited for any training or workshop on clinical care or social work".

Out of seven participants who took part in focus group discussion, only two of them had passed through medical care and legal support trainings. In general, seven participants out of thirteen had received skills in relation to gender-based violence trainings which were organized by Ministry of Attorney and Ministry of Women and Children, as noted in interviews and focus group discussion. On job training is a vital to update one's knowledge or skills in his/her career. In

Gandhi hospital's one stop center staff key service givers have attended planned trainings on medical, psychological and legal support in relation to gender based violence. Such trainings help trainees to perform effectively their duties. Participants suggested that, however, since the service of the center is made up of who come from different sectors, the training should be access to all.

#### **4.3.2. Theme 2: “essential kit/equipment”**

The availability of essential medical kit/equipment in the center was asked by the researcher to the interviewees. Participant 2 reported that “For your information, medicines are categorized as essential and non-essential by Federal Medicine Control Authority. For example, Hepatitis B vaccination and Emergency contraception post pills are labeled as non-essential for our hospital, but they are very essential. Except these medicines and vaginal discharge analysis, other essential equipment's are available. Participant 3 and 4 had reported the same story to participant 2.

In focus group discussion, all except one participant who reserved to be silent, reported that very essential equipment's to the center are out of stock, as they are labeled non-essential to the hospital. If very essential medical kits are not available in the center leads the total support of survivors incomplete. This in turn affects physical and psychological of survivors. The researcher observed the laboratory room of the center with its equipment's, by the help of lab technical. One participant requested an equipment which helps for vaginal discharge analysis.

#### **4.3.3. Theme 3: “follow up their treatment”**

The researcher asked the interviewees that to understand about survivors who under medical care and counseling follow up their treatment appropriately. Participant 2 reported that “Any person who was Our sexually violated would be properly treated in the center which is

opened for 24 hours a day. The center is considered as emergency case for survivors in the hospital. When one who is violated arrives to the center would be examined by center's doctors and provided all necessary treatments. Following the first examination, a survivor would be supposed to stay under medical care for certain days or to visit her doctor for further examination. Specially for pregnancy and HIV test after one month and three months respectively. Accordingly, to the decision of medical staff, survivors follow up their treatment appropriately." Regarding counseling provided to survivors, Participant 5 and 6 did suggest that" Some individual survivors have less attention to receive counseling. As to these individuals, they fear to be exposed themselves to the society around them. The reason behind their fear is culturally not to be disrespected by others. Some survivors' families also share this perception."

All participants who attended in the discussion of focus group session, noted that the survivors have preferred medical care than psychological and legal support. This notice supported to the reports of interview participants. One attendant of the focus group discussion noted that "the reason behind survivors' refusal of legal service support is, fear of wrong perceptions of the society around them. This practice leads victims to hide crimes. In other word, it paves a way to enhance sexual violence rather than bringing abusers or criminals in front of justice." From point of this statement, one of the participants seriously addressed to the government sectors that concerned sectors, which in charged to maintain the security of citizens, must look for such crimes as the safeguard. However, survivors appropriately follow up their medical treatment as to the decisions of doctors in the center. This is a good move, one participant uttered.

#### **4.3.4. Theme 4: "package of services and delivery model"**

Here, the researcher posed a question to understand about package of services and delivery model which provide to survivors who are under psychosocial service. To respond this question,

Participant 5 reported that: “I am psychological officer of the center. Psychological service is delivered to survivors from this team as to their age groups. Specially, there are different ways to communicate with child victims. So, package of service that the center delivers “*art therapy*” (children’s toy, drawing paper, blackboard, marker and the like). Telling “*fairy tales*” is also the best approach to persuade children’s attention for better understanding. In addition to this package the psychological service is supported by “*cognitive behavioral therapy*” delivery model. This model helps service givers to understand peoples’ behaviors behind their problems and indicates them that how behavioral change comes through interpersonal relationships.”

In focus group discussion, two participants mentioned about the setup of psychological service team room which is prepared to make conducive for children where to play. They also reported the same story to participant 5. Regarding the delivery model, which is applied in the center, they talked that there is shortage of skilled personnel. The researcher observed the setup of the room and children’s toy, it was impressive, but the materials display on narrow space.

#### **4.3.5. Theme 5: “safety and protection”**

The researcher attempted to understand that, what specific services provide to survivors under safety and protection, to respond this, participant 2 said that “whenever survivors reached to the center, they are safely treated and protected from any threat. Regarding to their health protection, they are provided sanitation materials, and the area where they receive any treatment is clean and COVID 19’s protocol is seriously applicable.” Concerning to security of survivors, since they are staying in the center, policemen look for them and watch the area, this was reported by participant 6.

In focus group discussion, the researcher raised a question about safety and protection of survivors who under treatment in the center. However, all participants shared the reports of

participant 2 and 6. The researcher also perceived while conducting interviews at the center, what the reality was the same to participants' reports.

#### **4.3.6. Theme 6: “police investigation and court decision”**

How long a police investigation takes to present a case to a court and a court decision to finalize a case? Following this question, participant 6 reported that “In this center, the duties of attorney and police service teams are to give advice survivors to help in the process of investigation and to deal with primary investigation. If survivors closely collaborate in the process of the investigation, it may finish within a month. And this primary investigation will be presented to survivors' respective sub-cities' justice offices. After winding up the investigation in sub-city, a lawsuit will be filed. A court decision will be estimate to finalize a case within six months.”

Regarding the time taken of police investigation and court decision, there are some delays in investigation process because of lack of positive perceptions and survivors' negligence as to the data. Participant 6 seriously noted that such negligence, in other way encourages crime against human right, by any means it must be stopped including national mobilization. However, the researcher was reported that police investigation and court decision may last about one month and six months respectively to finish a case.

#### **4.3.7. Theme 7: “constraints/limitations”**

The researcher asked interviewees to point out the main for providing expected treatment to survivors. Participant 2 said that “one of a limitation of a center is inadequate budget allotment, because regardless it broadens services, it is consider as one of case team in our hospital. In addition to this, post-pill and Hepatitis vaccination medications are not available in hospital, because these are labeled as non-essential to it, but they are very essential for the center. Absence

of DNA analysis medical tool nearby the hospital has disrupted the work of the center to detect the exact persons who committed violence against survivors.” Participant 3 reported the same story to participant 2. Some survivors are having less commitment to receive psychological support than medical treatment, reported by participant 5. Participant 6 also said that “budget is a big constraint to support victims who couldn’t afford even to buy what they need while staying in the center. Most of survivors need only medical care rather than receiving legal or psychological support.”

Most of the focus group discussion participants noted about budget constraint to provide adequate service to the survivors. One participant described that some victims do not want to take their cases to police because of making clandestine negotiation between victimized person and a person who committed violence. Another participant talked that at the middle of investigation some survivors would be corrupted and hide their address.

#### **4.3.8. Theme 8: “specific challenges”**

To detect the presence of specific challenges to provide services in one stop center of Ghandi hospital, the researcher asked the participants to point out challenges face the center’s service. Participant 2 said that “in our center one of a challenge which I found is absence of DNA analysis equipment which is very important to identify the exact person who committed the sexual violence. By now, doctors, in the center, have used the information of survivors whom they claimed. This kind of approach doesn’t help to identify the right man, however, I don’t mean that to have this equipment alone rather to have one at city level, as it costs big money.” Participant 5 noted that “in my part, since Ethiopia is diversified country, I face a challenge of communication barrier with survivors who speak only their mother tang, and the center has no interpreter for each

language. This barrier in turn has disrupted the psychological support to survivors.” Participant 6 reported the same story to that of participant 5, and added:

“There are survivors who would want to revenge their boyfriends, when they face conflict each other. In this regard I have one story to share you because it had impressed me at a time. It was that one lady visited our center as if she was sexually violated. To make short, when the lady was examined and found pregnant. Lately, through investigation, the center had realized that both were friends for about two years before the lady to visit the center. As to the lady, a man had shown to desert her, after he was informed that she will give him a birth, this denial forced her to report as if she was violated by him. However, since the center is known as an emergency case team for sexual violence, this case was not treated because it was irrelevant to the objective of the center service.”

One participant, on the discussion, noted that “there is workload in our center, since it is the earliest one to be established and has long time in service. Recently, Addis Ababa Health Office reorganized and redistributed the sub-cities into *four one stop centers*. Except Tirunesh-Bejing Hospital, others shared equal number of sub-cities for survivors to go to their respective sub-city. However, because of its location and longtime service survivors have come from all sub-cities. On the top of budget constraint, it is so difficult to support such a crowd of people.” When the researcher arrived, for conducting interview at the center, saw a crowd of people who wait their turn to see doctors. Meanwhile, she observed misunderstanding between service needy person and giver because of communication barrier in language.

#### **4.3.9. Theme 9: “evaluate services”**

How often evaluate services in rendering survivors in a center. Evaluation is the best tool to improve on services or activities based on planning which is a benchmark to evaluate any planned work. To this regard the researcher posed a question to the participants. All participants reported that the integrated service of the center has been evaluated monthly, quarterly and annually. And the delegates are responsible to report their performance to their respective sectors. They also said that their work activities are based on consensus and mutual understanding. In addition to the integrated activities evaluation approach, Gandhi memorial hospital planning and evaluation department is particularly, responsible to evaluate medical service team activity.

Similar another research conducted previously came up with a result which based on the types of services provided within the center, Kidist Mekonnen (2019) entitled ‘*Assessment of Post Rape Care Services in Gandhi Memorial Hospital Addis Ababa*’. However, this research identified results in different way of discussion which answered the research questions constructed in 9 thematic areas of detailed discussion and results of the study.

## **Chapter Five: Conclusion and Recommendation**

### **5.1. Conclusion**

The study was based on the constructivist paradigm and used qualitative research, phenomenological methodologies. Data sources included in-depth interviews, focus group discussion and observation. The constant comparison method was used to analyze data.

In this section presented the results and discussions from interviews and focus group discussion of six and seven participants respectively. Currently, staff members who have worked at least three years in one stop center integrated service, under Gandhi memorial hospital of the capital city, Ethiopia. Categories within each theme helped to support and provide insight into the themes.

The participants who have been serving in Gandhi's one stop center were exposed to the service are the only people that can truly evaluate the effectiveness of an integrated service initiative on their own center activities. Participants in this study clearly believed that the establishment of one stop center facilitated the beneficiaries to get medical cure, psychological and legal support easily at one place. Participants supported the notion that their academic knowledge and on job trainings improved because of their work experiences. These improved academic skills included the ability to collaborate with others in team spirit, obtain more effective integrated service giving skills, improve presentation skills, and become better organized. The service of the center was described by participants, despite some variations in how well they were implemented, appear to have promoted and facilitated the center readiness.

In addition to this, constraints and challenges that identified by participants included the shortage of budget, absence of essential medical equipment's, limitation of staff development at the center, survivors preferred medical support than legal support, survivors and their families not

to cooperate with legal service givers, and workload that the center was forced to serve the people who could come from all directions of Addis Ababa city residents.

Participants in the study also addressed trainings and workshops provided to the staff members of the center were sponsored and organized by Ministry of Attorney and Ministry of Women & Children Affairs, they generally tended to develop and utilize effective training strategies for integrated service of the center. Overall, participants believed that one stop center service is better for beneficiaries.

It also concluded that integrated services do seem to promote one stop centers for their beneficiaries, at least from the perspective of the staff members themselves. The participants in this study were able to clearly identify and describe the benefits of having a one stop center as they engaged in it. However, it is only a start to what hopefully will be a series of ongoing studies that examine the effectiveness of integrated service on one stop center to empower and promote service givers.

## **5.2. Recommendations**

This study made some recommendations in the areas of integrated service and center readiness. Further studies that evaluate these topics will be essential toward promoting and improving service of one stop center. Although this study did not evaluate various types of one stop center initiatives, it is probable that the better the service effectiveness at the center level. The metropolitan city of Addis Ababa, which is currently implementing in four sites, may serve as a model for one stop center implementation. Lessons from this state may prove to be relevant and meaningful for other regional states of the country. Based on the findings and conclusions, the researcher has recommended as follows:

**i. For Existing One Stop Center Service**

In Gandhi hospital's one stop center staff key service givers have attended planned trainings on medical, psychological and legal support in relation to gender based violence. Such trainings help trainees to perform effectively their duties. Participants suggested that, however, since the service of the center is made up of who came from different sectors, the training should be access to all. Additionally, service providers should allow and find ways to support survivors in their centers. This includes but is not limited to offer medical, psychological and legal support. All these supports are essential and helpful for survivors. The centers are unable to adequately prepare service providers for effective services. Service providers must be willing to seek online resources on a routine and regular basis. Service givers could then evaluate those resources and find ways to integrate them into their careers. With increased use of online resources, service providers could leverage in helping of survivors and provide timely. I think, providing trainings in relation to gender-based violence is vital. To this regard, the researcher would like to recommend that such type of trainings should be mainstreamed into education.

**ii. For Government Authorities and Policy Makers**

Addis Ababa City Administration already has believed that one stop center as an integrated service tool is important. This means that four hospitals are providing integrated services that allow hospitals to facilitate, collaborate, evaluate, enhance service delivery skills, and learn social etiquette among other things. Government authorities and policy makers must understand that integrated service is fundamental to both service seekers and givers. Administrators identify limited state funding as an ongoing barrier to offering more service in supporting survivors. That city administration and federal funding also must be flexible enough to accommodate centers' unique

service allocation needs. Most of the focus group discussion participants noted about budget constraint to provide adequate service to the survivors.

### **iii. For Survivors and their Families**

One participant described that some victims do not want to take their cases to police because of making clandestine negotiation between victimized person and a person who committed violence. Another participant also talked that at the middle of investigation some survivors would be corrupted and hide their address. The researcher was able to understand that why the victims and their families are refusing to collaborate with police investigators are, not to be exposed to the people who have still wrong perception about such violation. The other point also that survivors or their families seek money because of having poor or no income. As a result, some individuals are not cooperative, however, on the other way they unknowingly fail to stand against human right violation and deny the crimes. All people, regardless of gender and religious differences must be united and fight the rising sexual violence, victims and their families should cooperate with the people who investigate and bring criminals to trial rather than looking for temporary advantage and fearing the existing ill-perception of other people.

### **iv. Further Research**

Truly evaluating an effectiveness of one stop center integrated service is a difficult task. As a matter of fact, it is a complex organization that have multiple, ever-changing variables, including but not limited to variability in survivors, staff, programs, budgets, communities, and social factors. Further studies in this area should account for the many variances in integrated service providing centers that occur in hospitals. Every activity has different goals and implementations. It may be that certain types of programs or implementation models are better at facilitating one stop center readiness than others. Future studies should investigate in more complex ways the relationship

between integrated service initiative and one stop center readiness. More strong ways of determining integrated services' effectiveness need to be devised. Further research in this area may need to ensure greater homogeneity of the research sample.

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## Appendix

### Annex 1: Consent Form

My name is Timrawosen Tesfaye, I am a postgraduate student at Addis Ababa university department of Administration and Development Management, College of Business and Economics. I am conducting this research for the partial fulfillment of the master's degree of Public Management and Policy at Addis Ababa University.

The purpose of this study is to assess the effectiveness of services to examine the effectiveness of this one stop center in providing integrated service for survivors of violence in Mahatma Gandhi Memorial Hospital one stop center for academic purpose. The findings of the study can further be used as a reference guide for strengthen service quality and advocacy purposes in the future.

If you agree to take part in this research study, you will be interviewed with questions focused on the specified title. The interview should take 30-60 minutes. The questions will include background information, service availability within your sector, capacity development trainings and staff self-care plan. All information that you will provide will remain anonymous and confidential. Moreover, your participation in this study is consensual and based on your willingness. If you agree, we will start accordingly. You can also change your mind at any time during the interview/discussion. If you have any questions you can stop me at any time.

Thank you very much!

Code of participant \_\_\_\_\_

Signature of the researcher \_\_\_\_\_

**አባሪ 1: - የፍቃድ ቅጽ**

ስሜ ትምራውስን ተስፋዬ እባላለሁ ፣ በአዲስ አበባ ዩኒቨርሲቲ የአስተዳደር እና ልማት ማኔጅመንት ዲፓርትመንት ፣ ቢዝነስ እና ኢኮኖሚክስ ኮሌጅ የድህረ ምረቃ ተማሪ ነኝ ። ይህንን ጥናት የማካሄደው በአዲስ አበባ ዩኒቨርሲቲ የሁለተኛ ዲግሪ የንግድ በህዝብ አስተዳደር እና ፖሊሲ ለመመረቅ እንዲረዳኝ ነው።

የዚህ ጥናት ዓላማ ለትምህርት ግብአት ሲሆን ፣ በማሃተም ጋንዲ መታሰቢያ ሆስፒታል የተቀናጀ አገልግሎት ማእከል ጥቃት ለደረሰባቸው ሴቶች እና ህጻናት እየተሰጠ ያለውን የተቀናጀ አገልግሎት ውጤታማነት ለመመርመር ነው። ምርምሩ አላማ የጥናቱ ግኝቶች ለወደፊቱ የአገልግሎት ጥራትን የተሻለ ለማድረግ እና ለማጠናከር እንዲሁም ለሌሎች የጥናት ስራዎች ማጣቀሻ መመሪያ ሆነው ሊያገለግሉ ይችላሉ።

በዚህ የምርምር ጥናት ውስጥ ለመሳተፍ ከተሰማሙ በተጠቀሰው ርዕስ ላይ ያተኮሩ ጥያቄዎች ጋር ቃለ መጠይቅ ይደረግልዎታል። ቃለመጠይቁ ከ30-60 ደቂቃዎች ሊወስድ ይችላል። ጥያቄዎቹ አጠቃላይ መረጃን ፣ በእርስዎ ዘርፍ ውስጥ የአገልግሎት አቅርቦትን ፣ የአቅም ማጎልበቻ ሥልጠናዎችን እና የሰራተኞችን የሰራ ሁኔታ ያካትታሉ ። የሚሰጡዎቸው ሁሉም መረጃዎች ሚስጥራዊ ሆነው ይቆያሉ። በተጨማሪም ፣ በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ በፍቃደኝነትዎ ላይ የተመሠረተ ስምምነት ነው። ከተሰማሙ በዚህ መሠረት እንጀምራለን። እንዲሁም በቃለ መጠይቁ / ውይይቱ ወቅት ሃሳብዎን በማንኛውም ጊዜ መለወጥ ይችላሉ። ማንኛውም አይነት ጥያቄ ካሉዎት በማንኛውም ጊዜ ሊያስቆሙኝ እና ሊጠይቁኝ ይችላሉ ።

በጣም አመሰግናለሁ!

የተሳታፊ መለያ \_\_\_\_\_

የአጥኝ ፊርማ \_\_\_\_\_

## Annex 2. Key Informant Interview Guide

*Note: This tool is for use during interviews with service providers*

*Objective: To assess the integrated services involved in the one stop center*

I. What type of services do you provide to survivors of violence?

II. How long you work in the center?

- less than 1 year
- 1-3years
- 3-5 years
- Other? Please explain \_\_\_\_\_

III. What is your academic level?

- Diploma
- BA/BSC degree
- Master's degree
- Medical Doctor
- Other? Please explain \_\_\_\_\_

IV. How do you disseminate information about the integrated service in the center to the society?

- MAs media (TV, Radio)
- Social media (Facebook, Telegram, Website ....)
- Billboard
- Brochures, pamphlets
- Other? Please explain \_\_\_\_\_

V. How do you provide the services to survivors?

### Medical

1. The medical personnel received any specialized training on clinical care for survivors of sexual violence? \_\_\_\_\_ Who provided the training? \_\_\_\_\_

2. The medical personnel received any specialized training on the provision of care for child survivors of sexual violence? Who provided the training? \_\_\_\_\_
3. What are the complete essential medical kits/equipment available?
4. How many trained social workers on medical staffs do you have? \_How many medical staff have been trained in social work in your organization? \_\_\_\_\_
5. Do survivors who are under medical treatment follow-up their treatment appropriately?
6. How often do you evaluate your medical services?
7. What are the main constraints/limitations for providing expected medical treatment to survivors?

### **Psychosocial**

1. What package of services do you provide under psychosocial support? Please list  
\_\_\_\_\_
2. What is the delivery model/structure of the psychosocial support delivered to survivors?  
\_\_\_\_\_
3. The one stop center psychosocial services provided by:
4. How does the center work on awareness raising and stigma reduction within survivor's family? \_\_\_\_\_
5. What kind of training have the center volunteers and social workers received?  
\_\_\_\_\_
6. Do survivor's follow-up their counseling treatment properly as per schedules?
7. How often do you evaluate your psychosocial services?
8. What are the main constraints/limitations for providing psychosocial treatment to survivors?

**Safety and Protection**

1. What are the specific services do you provide? Please list \_\_\_\_\_
2. What are the main constraints/limitations for providing expected safety and protection to survivors?
3. Have you ever turned away survivors because of a lack of available resources?

**Legal**

1. After a police investigation of cases how long it takes to present a case to court? \_\_\_\_\_
2. Who follow-up cases in court closely?
5. How long a court decision takes approximately to finalize a case?
4. How often do you evaluate your legal services?
5. What are the main constraints/limitations for providing expected legal services to survivors?
6. What are the specific challenges you face on the process of providing legal service? \_\_\_\_\_

**Other Comments:**

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### አባሪ 3. ቁልፍ መረጃ ሰጭ ቃለ መጠይቅ መመሪያ

ማሳሰቢያ ይህ ቅፅ ከአገልግሎት አቅራቢዎች ጋር ቃለ-መጠይቅ በሚደረግበት ጊዜ ጥቅም ላይ ይውላል፡

የቃለ-መጠይቁ ዓላማ፡ በተቀናጀ አገልግሎት ማዕከል ውስጥ የተካተቱ የተቀናጁ አገልግሎቶችን ለመገምገም ነው።

#### ክፍል አንድ- የቃለ መጠይቅ ተሳታፊዎች መረጃ

I. የቃለ መጠይቅ ተሳታፊ ፆታ

- ሴት
- ወንድ

II. የቃለ መጠይቅ ተሳታፊ ዕድሜ

- ከ20-30 አመት
- ከ 31-40 አመት
- 41 እና ከዚያ በላይ

III. በማዕከሉ ውስጥ ለምን ያህል ጊዜ እየሰሩ ይገኛሉ?

- ከ 1 ዓመት በታች
- 1-3 ዓመታት
- ከ3-5 ዓመታት
- ሌላ? \_\_\_\_\_

IV. የትምህርት ደረጃዎ ምንድን ነው?

- ዲፕሎማ
- የመጀመሪያ ዲግሪ
- ሁለተኛ ዲግሪ
- የሕክምና ዶክተር
- ሌላ? እባክዎ ይግለጹ \_\_\_\_\_

#### ክፍል ሁለት: የመግቢያ ጥያቄዎች

ጥቃት ለደረሰባቸው ሰዎች ምን ዓይነት አገልግሎት ይሰጣሉ? እባክዎ ይዘርዝሩ \_\_\_\_\_

V. በማዕከሉ ውስጥ ስላለው የተቀናጀ አገልግሎት መረጃ ለህብረተሰቡ እንዴት ያሰራጫሉ?

VI. ጥቃት ለደረሰባቸው ሰዎች እንዴት አገልግሎቱን ይሰጣሉ?

VII. የማዕከሉ በር በማንኛውም ሰዓት ጥቃት ለደረሰባቸው ሰዎች ክፍት ነው? \_\_\_\_\_

**የህክምና አገልግሎት**

1. የህክምና ባልደረቦች ጾታዊ ጥቃት የደረሰባቸው አዋቂ ሰዎች ክሊኒካዊ እንክብካቤን በተመለከተ ማንኛውንም ልዩ እና አስፈላጊ ሥልጠና አግኝተዋል? \_\_\_\_\_ ስልጠናውን የሰጠው ማነው? \_\_\_\_\_

2. የህክምና ባልደረቦች ጾታዊ ጥቃት የደረሰባቸው ልጆች እንክብካቤን በተመለከተ ማንኛውንም ልዩ ሥልጠና አግኝተዋል? ስልጠናውን የሰጠው ማነው? \_\_\_\_\_

3. የተሟሉ አስፈላጊ የህክምና ዕቃዎች / መሣሪያዎች ምን ምን ናቸው?

4. በህክምና አገልግሎት ክፍል ውስጥ ምን ያህል የሰለጠኑ ማህበራዊ ሰራተኞች አሉ? \_\_\_\_\_ በማእከሉ ውስጥ በማኅበራዊ ሥራ ምን ያህል የህክምና ሠራተኞች ሥልጠና ተሰጥቷቸዋል? \_\_\_\_\_

5. በህክምና ላይ ያሉ ጥቃት የደረሰባቸው ሰዎች ሕክምናቸውን በአግባቡ ይከታተላሉ?

6. የህክምና አገልግሎቶችን በምን ያህል ጊዜ ይገመግማሉ?

7. የሚጠበቀውን የህክምና አገልግሎት ለመስጠት የሚገጥሟቸው ዋና ዋና ገደቦች / ውስንነቶች ምንድን ናቸው?

**በስነልቦና ማህበራዊ ድጋፍ አገልግሎት**

1. በስነልቦና ማህበራዊ ድጋፍ ምን ዓይነት አገልግሎት ይሰጣሉ? እባክዎን ይዘርዝሩ \_\_\_\_\_

2. ጥቃት ለደረሰባቸው የሚሰጡት የስነ-ልቦና ድጋፍ አሰጣጥ ሞዴል / መዋቅር ምንድነው? \_\_\_\_\_

3. የስነ-ልቦና የምክር አገልግሎቶች የሚሰጡት በማን ነው?

4. ማዕከሉ ጥቃት በደረሰባቸው ግለሰቦች ቤተሰቦች መካከል በግንዛቤ ማስጨበጫ እና መገለል ቅነሳ ላይ እንዴት ይሠራል?  
\_\_\_\_\_

5. የማዕከሉ በጎ ፈቃደኞች እና ማህበራዊ ሰራተኞች ምን ዓይነት ስልጠና አግኝተዋል? \_\_\_\_\_

6. ጥቃት የደረሰባቸው የሰነ-ልቦና ምክር አገልግሎት ሕክምናቸውን በሚገባ ይከታተላሉ?

7. የሰነ-ልቦና ማህበራዊ አገልግሎቶችን በምን ያህል ጊዜ ይገመግማሉ?

8. ጥቃት ለደረሰባቸው የሰነ-ልቦና ህክምናን ለመስጠት ዋና ዋና ገደቦች / ውስንነቶች ምንድናቸው?

**ደህንነት እና ጥበቃ**

1. በደህንነት እና ጥበቃ ስር የሚሰጡት ልዩ አገልግሎቶች ምንድናቸው? እባክዎን ይዘርዝሩ \_\_\_\_\_

2. ጥቃት ለደረሰባቸው ደህንነት እና ጥበቃን ለማቅረብ የሚያጋጥሙ ዋና ዋና ገደቦች / ውስንነቶች ምንድናቸው?

3. በቂ ፈንድ ባለመኖሩ ምክንያት ጥቃት የደረሰባቸው ሰዎች አገልግሎት ሳያገኙ ተመልሰው ያውቃሉ?

**የሕግ አገልግሎት**

1. ፖሊስ ጉዳዮችን ለፍርድ ቤት ለማቅረብ ምን ያህል ጊዜ ይፈጅብታል? \_\_\_\_\_

2. የፍርድ ቤት ጉዳዮችን በቅርበት የሚከታተለው ማነው?

3. የፍርድ ቤት ውሳኔን ለማጠናቀቅ በግምት ምን ያህል ጊዜ ይወስዳል?

4. የሕግ አገልግሎትዎን በምን ያህል ጊዜ ይገመግማሉ?

5. ጥቃት ለደረሰባቸው ሰዎች የሚጠበቁ/የሚያስፈልጉ የሕግ አገልግሎቶችን ለመስጠት ዋና ዋና ገደቦች / ውስንነቶች ምንድናቸው?

6. በሕግ አገልግሎት አሰጣጥ ሂደት ላይ የሚያጋጥሙዎት ልዩ ተግዳሮቶች ምንድናቸው? \_\_\_\_\_

### **Annex 3. Focus Group Discussion Guide**

*Note: Target participants: (5-7 Caregivers of the one stop center from medical, psychosocial and legal units based on their work experience in the center.*

*Objective: To assess the integrated services involved in the one stop center*

*Time 60-90 minutes*

#### **Introduce Self**

#### **Present the purpose of the discussion:**

- ❖ General information about the research
- ❖ Explain what I will do with this information and make sure that I do not make false promises
- ❖ Participation is voluntary
- ❖ No one is obligated to respond to any questions if s/he does not wish
- ❖ Participants can leave the discussion at any time
- ❖ No one is obligated to share personal experiences if s/he does not wish
- ❖ If sharing examples or experiences, individual names should not be shared
- ❖ Be respectful when others speak
- ❖ The facilitator might interrupt discussion, but only to ensure that everyone has an opportunity to speak and no one person dominates the discussion

#### **Agree on confidentiality:**

- ❖ Keep all discussion confidential
- ❖ Consent form

#### **Ask permission to take notes and recording:**

- ❖ No one's identity will be mentioned

- ❖ The purpose of the notes and recording is to ensure that the information collected is specific

## QUESTIONS

### **A. I would like to ask you some questions about the services and assistance available in this one stop center for sexual violence survivors:**

1. What is the main role of the OSC for the society and its major goal? What are the packages of services?
2. For services not provided by the center what are some of the alternative mechanisms you apply?
3. What medical referral mechanisms are currently in place and what are the reason behind of referrals?
4. How does the regular admission procedure look like?
5. How does the treatment look like for violence survivors?
6. What are some of the specialized trainings in relation to sexual violence and caring for adults and child survivors that are provided for the one stop center staffs?
7. What do the regular available care service packages consist of in your center?

### **B. I would like to ask you some questions about administrative matters:**

1. What are your source of financial and other resources? Are they sustainable?
2. Does the center face medical, counseling and legal professionals turn over? What are the reasons behind?
3. How do you evaluate your services? What are the key indicators?
4. Does the center have standard operational procedures?
5. What do you think are some of the challenges and limitations in rendering quality service provision for survivor of sexual violence in the center?
6. does the OSC have special benefit and allowances to staff members comparing to other common health centers?
7. how do you ensure sustainability of the service in the center?

8. What are the critical issues that needed to be addressed in order to make this center a success story and to scale up good practice?

**C. I would like to ask you some questions related to survivors**

1. How do you measure survivor's commitment on following up their medical, counseling treatment and legal/court process.
2. How do you see families support to survivors towards to continue the OSC service
3. How do you respond complaints from survivors?
4. How do you receive feedback from survivors regarding services provided?

**አባሪ 4. የትኩረት ቡድን የውይይት መመሪያ**

**ማሳሰቢያ:** የሚፈለጉ ተሳታፊዎች ቁጥር (5-7 በማዕከሉ ውስጥ ያሉ አገልግሎት ሰጪዎች በሕክምና ፣ በስነ-ልቦና እና በሕግ ክፍሎች ውስጥ ባላቸው የሥራ ልምድ መሠረት)

**የትኩረት ቡድን የውይይት ዓላማ-በተቀናጀ ማዕከል ውስጥ የተካተቱ የተቀናጁ አገልግሎቶችን ለመገምገም፡፡**

ውይይቱ የሚወስደው ጊዜ ከ60-90 ደቂቃዎች፡፡

የትኩረት ቡድን ውይይት ተሳታፊዎች ያታ

ወንድ

ሴት

የትኩረት ቡድን ውይይት ተሳታፊዎች ዕድሜ

ከ20-30 ዓመት

31-40 ዓመት

ከ 40 ዓመት በላይ

**ራስን ማስተዋወቅ**

**የውይይቱን ዓላማ ማቅረብ**

- ስለ ምርምሩ አጠቃላይ መረጃ
- በዚህ መረጃ ምን እንደሚደርግ ማስረዳት እና የማይሆን ተስፋዎችን እንደሚልሰጥ ማረጋገጥ
- ተሳትፎ በፈቃደኝነት መሆኑን መግለፅ
- ተሳታፊዎች ካልፈለገ ለማንኛውም ጥያቄ መልስ የመስጠት ግዴታ የለበትም
- ተሳታፊዎች ውይይቱን በማንኛውም ጊዜ ለቀው መውጣት ይችላሉ
- የማይፈልግ ከሆነ ማንም ሰው የግል ልምዶቹን የማካፈል ግዴታ የለበትም
- ምሳሌዎችን ወይም ልምዶችን ሲያካፍሉ የግለሰብ ስሞች መጠቀስ አይገባቸውም
- ሌሎች ሲናገሩ አከባሪ መሆን
- አስተባባሪው ውይይቱን ሊያቋርጥ ይችላል ፣ ግን ሁሉም ሰው የመናገር እድል እንዲኖረው እና ውይይቱን ማንም የሚቆጣጠር አካል እንደሌለ ለማረጋገጥ ብቻ ሲባል ነው፡፡

**ውይይቶች በሚሰጥር መያዛቸውን ማረጋገጥ እና መስማማት**

- ሁሉም ውይይቶች በሚሰጥር ይያዛሉ
- የፈቃድ ቅጽ ማስፈረም

**ማስታወሻዎችን ለመያዝ እና ለመቅዳት ፈቃድ መጠየቅ:**

- የማንም ማንነት አይጠቀስም
- የማስታወሻዎቹ ዓላማ የተሰበሰበው መረጃ የተወሰነ መሆኑን ለማረጋገጥ ነው

**ጥያቄዎች**

**ሀ/ ጾታዊ ጥቃት የደረሰባቸው ሰዎች በዚህ ማቆያ ማዕከል ውስጥ ስለሚያገኙት ዕርዳታ እና አገልግሎቶች አንዳንድ ጥያቄዎችን ልጠይቅዎት እፈልጋለሁ።**

1. ይህ የተቀናጀ ማእከል የተቋቋመበት ዋና አላማ እና ለህብረተሰቡ ያለው ሚና ምንድነው? የአገልግሎት ፓኬጅችሽ ምን ምን ናቸው?
2. በማዕከሉ ለማይሰጡት አገልግሎቶች ማእከሉ የሚተገብራቸው አማራጭ ዘዴዎች ምንድን ናቸው?
3. በአሁኑ ጊዜ ምን ዓይነት የሕክምና ሪፈራል ስልቶች አሉ? ከሪፈራሎች በስተጀርባ ያሉት ምክንያቶች ምንድናቸው?
4. የማእከሉ መደበኛና የየለት አሰራር ሂደት ምን ይመስላል?
5. ጥቃት የደረሰባቸው ሰዎች የሚያገኙት የሕክምና ሂደት ምን ይመስላል?
6. ከወሲብ ጥቃት ጋር በተገናኘ ጥቃት የደረሰባቸውን አዋቂዎች እና ህፃናት ለሚንከባከቡ ሰራተኞች የተሰጣቸው ልዩ ሥልጠናዎች ምንድናቸው?
6. በመደበኛነት የሚገኙ የአገልግሎት ፓኬጅች በማእከልዎ ውስጥ ምን ምን ያካትታሉ?

**ለ / ስለ አስተዳደራዊ ጉዳዮች አንዳንድ ጥያቄዎችን ልጠይቅዎት እፈልጋለሁ-**

1. የገንዘብ እና ሌሎች የማእከሉ መተዳደሪያ ምንጭ ምንድን ነው? ምንጮቹ ዘላቂ ናቸው?
2. የማዕከሉ የህክምና ፣ የምክር እና የህግ ባለሙያዎች ከስራ ይለቃሉ፤ ቶሎ ቶሎ ይቀያየራሉ? ዋና ዋና ምክንያቶች ምንድናቸው?
3. አገልግሎቶቻችሁ እንዴት ይገመገማሉ? ቁልፍ አመለካኾች ምንድናቸው?
4. ማዕከሉ መደበኛ የአሰራር ሂደቶች አሉት?
5. በማዕከሉ ውስጥ ጾታዊ ጥቃት ለደረሰባቸው ሰዎች ጥራት ያለው አገልግሎት ለመስጠት የሚገጥሟችሁ አንዳንድ ተግዳሮቶች እና ውስንነቶች ምንድናቸው ብለው ያስባሉ?
6. ማዕከሉ ከሌሎች የተለመዱ የጤና ማዕከላት ጋር ሲወዳደር ለሰራተኞች ልዩ ጥቅማጥቅም አለው?
7. በማዕከሉ ውስጥ የአገልግሎቱን ዘላቂነት እንዴት ያረጋግጣሉ?
8. ይህንን ማዕከል የስኬት ታሪክ ለማድረግ እና ጥሩ ልምድን ለማሳደግ ትኩረት ሊደረግባቸው የሚገቡ ወሳኝ ጉዳዮች ምንድናቸው?

**ሐ / ጥቃት ከደረሰባቸው ጋር የተያያዙ አንዳንድ ጥያቄዎችን ልጠይቅዎት እፈልጋለሁ**

1. ማእከሉ ጥቃት የደረሰባቸው ሰዎች የሕክምና ፣ የምክር አገልግሎት እና የሕግ/የፍርድ ቤት ሂደትን ለመከታተል ያላቸውን ቁርጠኝነት እንዴት ይለካሉ?
2. ማእከሉ አገልግሎቱን ከመቀጠል አኳያ ጥቃት የደረሰባቸው ሰዎች ቤተሰቦች ያላቸውን አስተዋፅኦ እንዴት ይመለከታሉ?
3. ጥቃት ከደረሰባቸው ሰዎች ለሚነሱ ቅሬታዎች ምላሽ በምን መልኩ ይሰጣሉ?
4. በማእከሉ ከሚሰጡት አገልግሎቶች ጋር በተያያዘ አዎንታዊ ወይም አሉታዊ አስተያየቶችን እንዴት/በምን መንገድ ይቀበላሉ?

## Annex 4: Observation Checklist Guide

<b>Health Sector Observation Checklist</b>	<b>Met</b>	<b>Not Met</b>
Female medical personnel include clinical health workers trained in provision of clinical management of sexual violence.		
Linkage with case worker/female social worker (internal/external)		
Complete supplies and medications for offering post-rape treatment are available? - Emergency contraception - STI medicines / antibiotics - Hepatitis B vaccination - Tetanus vaccination - HIV testing kit		
Safe and confidential space for examining survivors available		
Facility-level protocols in place for receiving sexual violence survivors and managing clinical care		
Non-identifying exit/entry into facility and examination spaces for survivors		
<b>Psychosocial Sector Observation Checklist</b>	<b>Met</b>	<b>Not Met</b>
Safe, locked filing space to keep survivors records confidential exist		
Procedures are in place for working with child survivors		
Child friendly materials (toys, art materials, dolls) are available in counseling rooms for case management staff to use with child survivors		
Case management staff trained in on survivor-centered care		
Supervision systems exist for case workers		
Private counseling room is available		
Do care givers spend enough time with survivors to understand their pain		
Do survivors get relief after getting counseling treatment		
Female case workers within the staff		
<b>Legal Sector Observation Checklist</b>	<b>Met</b>	<b>Not Met</b>
Safe, locked filing space to keep survivors police report, digital document and legal records confidential exist		
Temporary safe house/shelter for survivors facilitated		
Female police/legal case workers within the staff		

## **Annex 5. Guiding principles when working with GBV Survivors**

When a survivor comes forward requesting support after experiencing an incident of GBV, all responsible actors involved in providing services to the survivor should follow certain standards of conduct and behavior. This standard treatment is called the guiding principles. GBV guiding principles were established to ensure that the key actors working to respond to and prevent gender-based violence provide service without causing additional harm to the survivor unintentionally or intentionally. Guiding principles are considered as internationally accepted minimum standards to ensure a survivor receive the best care possible. The following are the guiding principles when providing services to survivors:

**Ensure the physical safety:** Safety refers to both physical safety and security, as well as to a sense of psychological and emotional safety for people who are highly distressed. It is important to consider the safety and security needs of each survivor, her family members and those providing care and support. (Interagency Gender-Based Violence Case Management Guidelines, 2017). In addition to the traumatic side effects that can affect an individual 's physical, emotional, social and psychological well-being, individuals who experience incidents of GBV often have security and safety concerns. In many cases, the perpetrator may threaten the individual if she reports the abuse. In other situations, the survivor might perceive that a threat still exists. In most cases violence against women and girls is perpetrated by their own family members or people in the community with whom they are well acquainted with which puts their security and safety at higher risk. Service providers, who support survivors of violence, need to be aware of the safety and security risks before intervening or assisting a client. The actions taken by service providers may worsen the safety and security concerns especially if they are not thoughtful of the consequences. Therefore, the safety and security of the survivor should be prioritized by all service providers. It

is important to ensure that the survivor and the service provider are not placed at risk or further harm by the perpetrator. The service provider should be conscious of any harm that the survivor may inflict on herself as well. Accordingly, establishing a safety plan with the survivor will help identify safety concerns.

**Guarantee Confidentiality:** Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Breaching confidentiality can put the survivor and others at risk of further harm. If helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help (IASC, 2017).

Confidentiality is the foundation of support for a survivor of GBV. The survivor 's anonymity should be maintained at all times. The personal information and any identifying information should not be disclosed without the survivor 's consent. Accordingly, all written information about the survivor must be kept locked and secured from others.

**Respect the wishes, the rights and dignity of the survivors:** GBV is an assault on the dignity and rights of a person, and all those who encounter survivors have a role to play in restoring dignity and self-determination. For example, survivors have the right to decline case management services or choose whether to access legal and other support services. Failing to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame, self-blame, reduce the effectiveness of interventions and cause re-victimization and further harm (IASC, 2017).